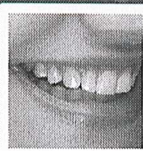
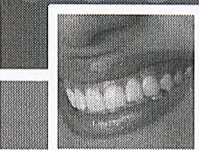
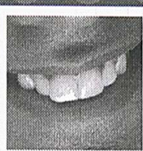
David Tillman, DDS
747 8th Avenue, Suite C
Fort Worth TX 76104

(817)332-9303

www.tillmansmiles.com







Welcome to our Practice

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ______ SS #. ______ Prev. Visit: ______

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______
______ City ______ State ______ Zip Code

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______ Phone: ______

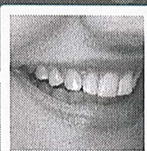
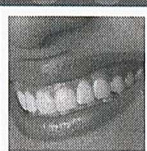
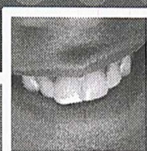
Address: ______ ______
______ City ______ State ______ Zip Code

Whom may we thank for referring you to our practice?

______

In an emergency who should be notified? Please enter Name and Phone number below:

______

Responsible Party Information:

This only need to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ SS #. ______ Driver's License #: ______

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______
______ City ______ State ______ Zip Code

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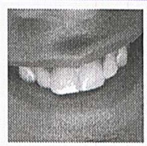


Primary Dental Insurance:

Name of Insured: ______ Last ______ First ______ MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ City ______ State ______ Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ City ______ State ______ Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______

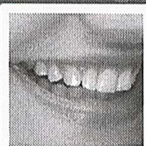
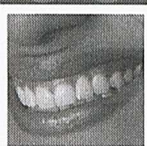
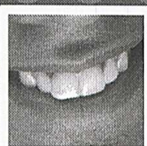
Insurance Address: ______ ______
______ City ______ State ______ Zip Code

Insurance Company Phone Number:

______

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

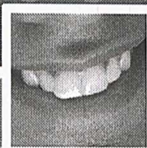
Medical History

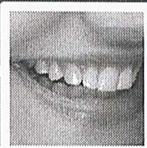
Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] **TAKING MEDICATIONS
- [ ] *Pre-Med - Other
- [ ] Allergy - Augmentin
- [ ] Allergy - Hay Fever
- [ ] Allergy - Other
- [ ] Anemia
- [ ] Asthma
- [ ] Cancer Treatment
- [ ] Dizziness
- [ ] Fainting
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Jaundice
- [ ] Low Blood Pressure
- [ ] Oral Contraceptives
- [ ] Pregnancy
- [ ] Rheumatic Fever
- [ ] STD
- [ ] Tobacco Use
- [ ] Ulcers

- [ ] *Pre-Med - Amox
- [ ] Allergies
- [ ] Allergy - Codeine
- [ ] Allergy - Keflex
- [ ] Allergy - Penicillin
- [ ] Arthritis
- [ ] Blood Disease
- [ ] Cancer
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Heart Murmur
- [ ] High Blood Pressure
- [ ] Kidney Disease
- [ ] Mental Disorders
- [ ] Other
- [ ] Radiation Treatment
- [ ] Rheumatism
- [ ] Stomach Problems
- [ ] Tuberculosis
- [ ] Venereal Disease

- [ ] *Pre-Med - Clind
- [ ] Allergy - Aspirin
- [ ] Allergy - Erythro
- [ ] Allergy - Latex
- [ ] Allergy - Sulfa
- [ ] Artificial Joints
- [ ] Blood Thinners
- [ ] Diabetes
- [ ] Excessive Bleeding
- [ ] Head Injuries
- [ ] Hepatitis C
- [ ] HIV
- [ ] Liver Disease
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Respiratory Problems
- [ ] Sinus Problems
- [ ] Stroke
- [ ] Tumors
- [ ] Vertigo





- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above needs further clarification, please describe below:

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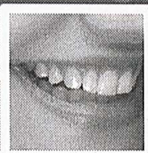
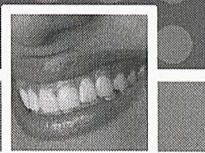
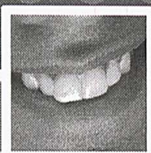




Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of your physician, phone number, and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

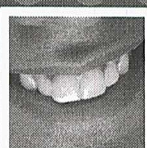
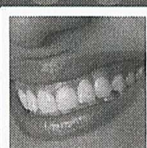
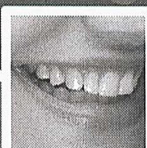
Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam/x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal History, Check all that apply:

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb
- ☐ Had/have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

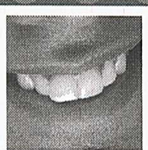
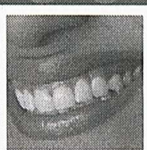
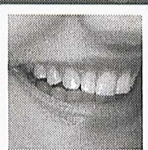
- ☐ Is there anything about the appearance of your teeth that you would like to change?
- ☐ Have you ever whitened (bleached) your teeth?
- ☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
- ☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- ☐ You have problems with your jaw joint
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
- ☐ Your teeth are crowding or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- ☐ You clench your teeth in the daytime or make them sore
- ☐ You have problems with sleep or wake up with an awareness of your teeth
- ☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- ☐ Cavities within past 3 years
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth

- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth

Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

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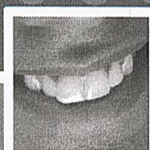
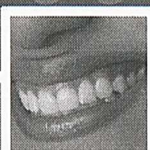
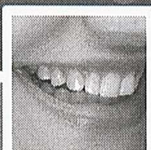

Financial Policy

We accept many PPO insurance plans, it is ultimately your responsibility to verify with your carrier whether our Dentist will be considered in-network for your specific insurance plan. If your carrier processes the claims as an out-network-charge, you will still be financially responsible for paying the charge in full.
If you have an out-of-network insurance plan for our office, you will be expected to pay your estimated portion in full at the time of your visit. In a case that your insurance pays more than expected, you will then be reimbursed directly by our office.

There will be a charge of $50.00 for missed restorative appointments, and $25.00 for a missed hygiene appointment without 24-hour cancellation notice. You may leave a message after business hours on our answering machine. Messages left over the weekend wanting to cancel/reschedule an appointment scheduled the following Monday are NOT considered a 24-hour notice.

Patients who have not arrived within 15 minutes of their appointment time will be re-scheduled. If you are late for two consecutive appointments, you will be charged a $50.00 fee for a missed appointment.

Payment is due at the time of service for all patients.

You will be responsible for your estimated portion of the procedure/surgery at the time of service. Our office will file the claim to your insurance company and you will receive an explanation of benefits from your insurance company. After the claim is processed, you will receive a statement from our office if your financial responsibility is different from the original estimated payment. You are responsible for paying your charges in full.

Our office will file your insurance claim a maximum of 2 times per appointment. If your claim is not paid by your insurance carrier within 60 days, you will be responsible for the balance and further insurance appeal becomes your responsibility.

We have the right to report your account status to any credit reporting agency such as a Credit Bureau after 90 days, and a blemish may be placed on your credit report.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collections cost which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur, plus all court cost.

You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If this document is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

If a patient is late to an 8:00 AM appointment, or an appointment at 4:00pm or after, the patient will no longer be able to schedule appointments with our practice during early and late appointment slots.

The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy.

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ By checking this box, I understand the above information and agree with its contents.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

I agree that all of the information I have given is accurate

Signature: ______________________ Date: __________